- **Medical Plan Comparison Chart**

UPEC

Plan Year 2010

Medical Plans Comparison Chart

	CalPERS Blue Sheild Net Value HMO-** CalPERS Blue Shield HMO*	CalPERS Kaiser HMO*	PEBT Kaiser HMO	PEBT HealthNet HMO	PEBT PacifiCare HMO	CalPERS Select PPO – ** CalPERS PERSChoice PPO*		CalPERS PERSCare PPO*		PEBT PPO	
						In-Network	*Out-Of-Network*	*In-Network*	*Out-Of-Network*	*In-Network*	*Out-Of-Network*
Calendar Year Deductible	None	None	None	None	None	$500 individual $1,000 family		$500 individual $1,000 family		$500 individual $1,500 family	
Out-Of-Pocket Maximum	None	None	None	None	None	$3,000 individual $6,000 family	None	$2,000 individual $4,000 family	None	$4,000 individual	$6,000 individual
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	$2,000,000		Unlimited		$5,000,000	
Physician Office Visits	$10 copay/visit	$10 copay/visit	$10 copay/visit	$10 copay/visit	$10 copay/visit	$20 copay/visit	You pay 40%	$20 copay/visit	You pay 40%	$20 copay/visit (deductible waived)	You pay 40%
Diagnostic Lab & X-Ray	No charge	No charge	No charge	No charge	No charge	You pay 20%	You pay 40%	You pay 10%	You pay 40%	You pay 80% after deductible	You pay 40% after deductible
Annual Physical Exams	$10 copay/exam	$10 copay/exam	$10 copay/exam	$10 copay/exam	$10 copay/exam	No charge	You pay 40%	No charge	You pay 40%	$20 copay/visit (through age 16)	Not covered
Well Baby Care	$10 copay/visit	$10 copay/visit	No charge (up to age 2)	$10 copay/visit (up to age 2)	No charge (up to age 2)	No charge	You pay 40%	No charge	You pay 40%	$20 copay/visit	Not covered
Emergency Room	$50 copay/visit; waived if admitted	$50 copay/visit; waived if admitted	$50 copay/visit; waived if admitted	$50 copay/visit; waived if admitted	$50 copay/visit; waived if admitted	You pay 20% after $50 deductible; waived if admitted	You pay 20% after $50 deductible; waived if admitted	You pay 10% after $50 deductible; waived if admitted	You pay 10% after $50 deductible; waived if admitted	$100 copay (if admitted, 20% after deductible)	$100 copay (if admitted, 20% after deductible)
Hospital Services	No charge	No charge	No charge	No charge	No charge	You pay 20%	You pay 40%	You pay 10% ($250/ admission inpatient facility deductible)	You pay 40% ($250/ admission inpatient facility deductible)	You pay 20% after deductible	You pay 40% after deductible; $600 max. allowable each day
Prescription Generic Brand Non-formulary	*30-day supply* [1] $5 copay $15 copay $45 copay ($30 if medically necessary)	*30-day supply* $5 copay $15 copay N/A	*100-day supply* $10 copay $15 copay	*30-day supply* $10 copay $15 copay $35 copay	*30-day supply* $10 copay $20 copay $40 copay	*30-day supply* [1 2] $5 copay $15 copay $45 copay ($30 if medically necessary)	*30-day supply* [1 2] $5 copay $15 copay $45 copay ($30 if medically necessary)	*34-day supply* [1 2] $5 copay $15 copay $45 copay ($30 if medically necessary)	*34-day supply* [1 2] $5 copay $15 copay $45 copay ($30 if medically necessary)	*30-day supply* $10 copay $15 copay 50% copay	*30-day supply* $10 copay plus 50% $15 copay plus 50% $15 copay plus 50%
Mental Health Inpatient Outpatient	 No charge; up to 30 days/cal. yr. $20 copay/visit; up to 20 visits/ cal. yr.	 No charge; up to 30 days/cal. yr. $20 copay/visit; up to 20 visits/ cal. yr.	 No charge $10 copay/visit; up to 20 visits/ cal. yr.	 No charge $30 copay/visit; up to 20 visits/ cal. yr.	 No charge $10 copay/visit; up to 30 visits/ cal. year	 You pay 20%; up to 20 days/cal. yr. You pay 20%; up to 24 visits/cal. yr.	 You pay 40%; up to 20 days/cal. yr. You pay 40%; up to 24 visits/cal. yr.	 You pay 10%; up to 30 days/cal. yr. ($250/ admission inpatient facility deductible) You pay 10%; up to 30 visits/cal. yr.	 You pay 40%; up to 30 days/cal. yr. ($250/ admission inpatient facility deductible) You pay 40%; up to 30 visits/cal. yr.	See Evidence of Coverage (EOC).	
Substance Abuse Inpatient Outpatient	 No charge $10 copay/visit; up to 20 visits/ cal. yr.	 No charge $10 copay/visit; up to 20 visits/ cal. yr.	 No charge $10 copay/visit	 No charge $30 copay/visit; up to 20 visits/ cal. yr.	 No charge Not covered	*$12,000 lifetime max. combined w/ out-of-network* You pay 20%; up to 20 days/cal. yr. You pay 20%; up to 24 visits/cal. yr.	*$12,000 lifetime max combined w/ in-network* You pay 40%; up to 20 days/cal. yr. You pay 40%; up to 24 visits/cal. yr.	*$12,000 lifetime max. combined w/out-of-network* You pay 10%; up to 15 days/cal. yr. ($250/ admission inpatient facility deductible) You pay 10%; up to 30 visits/cal. yr.	*$12,000 lifetime max. combined w/in-network, inpatient and outpatient* You pay 40%; up to 15 days/cal. yr. ($250/ admission inpatient facility deductible) You pay 40%; up to 30 visits/cal. yr.	See Evidence of Coverage (EOC).	

[1]Implementation of specialty & biotech drug management, education & compliance programs for the following: Asthma, Rheumatoid arthritis, Multiple sclerosis, Cancer treatment/blood modifying agents, Hepatitis C, Psoriasis & Growth hormones. Implementation of promotion of over-the-counter (OTC) drugs when available.

[2] Mandatory mail service for maintenance drugs. Mail Service would be mandatory after the 2nd fill of Rx at retail pharmacy OR Member will be charged the appropriate mail service copay for a one month supply at retail.

*PERS eligible UPEC members only.

** These benefit summaries only highlight your benefits. They are not summary plan descriptions (SPDs). If any discrepancy exists between this summary and the official documents, the office documents will prevail.

** Smaller network of high performance providers.